APPLICATION FOR ADVANCE PAYMENT

Michigan Department of Labor & Economic Growth Workers' Compensation Agency P.O. Box 30016, Lansing, MI 48909

INSTRUCTIONS TO APPLICANT: Only applicants who are currently receiving workers' compensation benefits may file this form. It should be completed and mailed to the above address. No action will be taken on this application unless you answer all questions in Section 1 (numbers 1 through 14) and sign your name under "Applicant Signature."

SECTION 1: TO BE COMPLETED BY APPLICANT

Social Security Number	2. Date of Injury	3. Employee Name (Last	, First, Middle Initial)	
I. Employer Name		5. Insurance Company N	5. Insurance Company Name (if applicable)	
Applicant Name (if other than employee)		7. Relationship to Employ	/ee	
8. Applicant Street Address		9. City, State, ZIP Code	9. City, State, ZIP Code	
0. Amount of Advance Requested	11. If amount is part of the take repayment from	l ne remaining weekly benefits due, the	If amount is from next payments due, repay by reducing weekly rate by	
\$	Next L	Last Payments Due	\$	
discount be taken, do you still w Yes No 14. Clearly state your reason(s) for				
Applicant Signature		Date	Date	
Attorney Name (if applicable)		Attorney ID #		
		P-		
ECTION 2: TO BE COM	IPLETED BY CAR	RRIER		
			Is the discount requested?	
Does the carrier agree with the terms Yes No			Is the discount requested? Yes No	
Ooes the carrier agree with the terms Yes No	of the advance payment red		·	
Does the carrier agree with the terms	of the advance payment red	quest? rier Name	Yes No	